

<b>Case Number:</b>	CM14-0180523		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	01/17/2011
<b>Decision Date:</b>	01/20/2015	<b>UR Denial Date:</b>	10/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of January 17, 2011. In a Utilization Review Report dated October 10, 2014, the claims administrator failed to approve a request for a lumbar home traction unit and also failed to approve a request for multimodality transcutaneous electrotherapy device. The claims administrator stated the decisions were based on an RFA form received on October 3, 2014. The applicant's attorney subsequently appealed. In a handwritten progress note dated September 26, 2014, the applicant reported ongoing complaints of low back pain. The applicant was reporting frequent flare ups of the same. The applicant stated that previous usage of lumbar traction device had generated pain relief. The applicant also stated that he needed a replacement cane as well as a replacement of multimodality transcutaneous electrotherapy device. The applicant's work status was not furnished. Acupuncture was sought. The applicant was given a shot of Toradol for reportedly worsened low back pain. The applicant was given a primary diagnosis of lumbar radiculopathy status post earlier lumbar microdiscectomy on November 2012 and secondary diagnosis of left shoulder pain status post earlier left shoulder surgery in June 2011. On July 2014, the applicant was reportedly unchanged, reported ongoing complaints of low back pain radiating to the leg. The applicant was on Norco, Tramadol, and Robaxin. A home traction device, replacement multimodality transcutaneous electrotherapy device, and permanent work restrictions were renewed. The applicant did not appear to be working with said limitations in place.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Home traction unit for lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back Lumbar & Thoracic (Acute & Chronic) (updated 08/22/2014)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 308, traction, the article at issue, is "not recommended" in the management of low back complaints as are/were present here. Page 98 of the MTUS Chronic Pain Medical Treatment Guidelines, furthermore, takes a position that passive modalities, as a whole, should be employed "sparingly" during the chronic pain phase of a claim. In this case, the concomitant request for a home traction device plus provision of a replacement multimodality transcutaneous electrotherapy device, suggest a reliance on passive modalities and passive therapies which is at odds to page 98 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.

**Replacement ART MEDS-4 Unit for pain: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of TENS Page(s): 115.

**Decision rationale:** As noted on page 115 of the MTUS Chronic Pain Medical Treatment Guidelines, provision of transcutaneous electrotherapy device beyond an initial one-month trial should be predicated on evidence of favorable outcome during said one-month trial, in terms of both pain relief and function. In this case, however, previous usage of the transcutaneous electrotherapy device has failed to generate requisite improvements in pain and/or function. The applicant remains dependent on various forms of medical treatment, including medications such as Norco, tramadol, and Robaxin. The applicant is seemingly not working with permanent limitations in place. Permanent work restrictions were renewed, unchanged, from visit to visit. All of the foregoing, taken together, suggested a lack of functional improvement as defined in MTUS 9792.20f, despite previous usage of the Artmeds-4 transcutaneous electrotherapy device. Therefore, the request for replacement unit is not medically necessary.